

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXXX**

**Petitioner**

**v**

**File No. 123096-001-SF**

**Blue Cross Blue Shield of Michigan**

**Respondent**

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**Issued and entered**  
**this 20th day of January 2012**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On August 26, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under Public Act No. 495 of 2006, MCL 550.1952 *et seq.* The Commissioner reviewed the request and accepted it on September 2, 2011.

The Commissioner immediately notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review request and requested the information it used to make its final adverse determination. The Commissioner received BCBSM's response on September 13, 2011.

The Petitioner receives health care benefits as a retiree of the City of XXXXX, a local unit of government self-funded health plan under Act 495. The plan is administered by BCBSM. Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in BCBSM's *Community Blue Group Benefits Certificate* (the certificate).

From November 3, 2010 to February 21, 2011, the Petitioner received dialysis services at the XXXXX Dialysis Center (XXDC) in XXXXX, XXXXX. The charge was \$60,100.30. DVDC does not participate with BCBSM.

BCBSM denied coverage for the dialysis. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and then issued a final adverse determination dated July 25, 2011, upholding the denial.

## III. ISSUE

Is BCBSM required to cover the Petitioner's dialysis services provided by a nonparticipating provider?

## IV. ANALYSIS

### Petitioner's Argument

The Petitioner, a resident of XXXXX, XXXXX, has been diagnosed with end stage renal disease (ESRD) and requires dialysis. He states he did not realize at the time that XXDC was not in BCBSM's network. However, he wants BCBSM to approve his dialysis there because it is the only dialysis provider in the area. He states his other choice would be to drive 172 miles round trip three times a week to XXXXX, XXXXX.

He wants BCBSM to retroactively cover the dialysis so the charges can be paid.

### BCBSM's Argument

BCBSM advised the Petitioner in its final adverse determination:

. . . We are unable to allow payment for the dialysis services provided by XXXXX Dialysis because they are not a benefit of your contract. . . .

You are covered under the *Community Blue Group Benefits Certificate*. As explained on page 3.34 under **Freestanding ESRD Facility Services**:

We pay for medically necessary facility services provided by a BCBSM panel or participating end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney disease.

In the same section, it indicates that "Services provided by a **nonparticipating** end stage renal disease facility" are not payable.

Our records indicate that XXXXX Dialysis is a nonparticipating ESRD facility. Services by a nonparticipating ESRD facility are not a benefit of your contract. Therefore, we are unable to approve payment.

BCBSM indicates that DVDC has facilities in both the contiguous states of XXXXX and XXXXX and that while the XXXXX facility participates with a local Blue Cross and Blue Shield host plan, the facility in XXXXX does not.

The dialysis services were prescribed by a physician and were medically necessary but they were not provided and billed by a participating ESRD facility. Therefore, BCBSM argues the services are not payable.

#### Commissioner's Review

BCBSM would have covered the Petitioner's dialysis services if they had been provided in a facility that participated with BCBSM or a local Blue Cross and Blue Shield plan in another state. Unfortunately, the XXDC in XXXXX, XXXXX, does not participate with either.

The certificate is clear: dialysis is not covered except from a participating facility. In Section 3 under "Freestanding ESRD Facility Services" (p. 3.34 – 3.35), the certificate states:

We pay for medically necessary facility services provided by a BCBSM panel or participating end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney disease.

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#### **Services That Are Not Payable**

- Services provided by a nonparticipating end stage renal disease facility.

The Commissioner understands why the Petitioner wanted to have the dialysis provided close to his home. However, there is nothing in the certificate or state law that requires BCBSM to cover dialysis services from a nonparticipating provider even if there are no participating providers conveniently available.

The Commissioner finds that BCBSM's denial is consistent with the terms of the certificate.

**V. ORDER**

Blue Cross Blue Shield of Michigan's final adverse determination of July 25, 2011, is upheld. BCBSM is not required to cover the Petitioner's dialysis from November 3, 2010 through February 21, 2011, from a nonparticipating provider.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton  
Commissioner